and pupillary reflexes normal; specific senses normal; evacuation of bowels every four to eight days; no disturbances of bladder.

CASE II.—Boy, 16 years old, much exposed to humidity and excessive work; no alcoholic excesses; no onanism; no coitus; the disease began after a typhoid-like febrile attack; symptoms and course of disease similar to those of Case I. The chief points of difference are: No asymmetry of face; paralytic symptoms limited to the feet, but marked ataxy of the lower extremities; cannot stand without support. Paroxysms of pain in the nails, feet, calves and knees, extremely violent, more intense than in Case I., of a lancinating contusive character—at the beginning he could still perform the most complex movements with the hands and fingers (which was not possible in the first case), although accompanied by irregular rapid oscillations; knee-jerks first exaggerated, later diminished in one of them; *pied bot* of both feet.

CASE III.—Boy of 12 years; disease began in the same manner as in the previous cases at the age of six; nearly analogous to Case II, but *pied bot* of one foot only; paroxysms of pain unilateral; knee-jerks absent.

The three cases have in common:

The astasia, ataxy, tremor, nystagmus, the spastic rigidity, the deformity, especially of the feet, the long absence of disturbances in the function of the bladder and rectum; the familiary heredity; (the symptoms mentioned heretofore forming the complex of Friedreich's disease), the starting of the disease with febrile typhoid-like attacks, the slow development with symptoms of debility, the latter preceded by disturbances of cordination and followed by paroxysms of violent pain of a contusive lancinating character; the predominance of the motor disturbances in the lower extremities, the gradual but progressive development of sensory disturbances.

Special peculiarities of the first case were: The intensity and extent of the paretic symptoms; the arrest of development, if not atrophy, of muscles. The second case showed the peculiarity of exaggerated knee-jerks.

This exaggeration of the knee-jerks in one case would speak in favor of the view that this case was of cerebellar origin, while the absence of the knee-jerks in the other two cases would make a cerebellar anatomical substratum, probable for them. But otherwise there is such an analogy in the symptoms and course of the disease of all three cases that, considering the familiarity, "it seems unnatural" to assume that they had a different anatomical basis. The author finds that a clinical distinction between purely cerebellar or purely spinal hereditary ataxy on one side and cerebellar and spinal ataxy on the other side cannot be made. F. seems to assume chiefly cerebellar origin for Friedreich's disease, as he calls attention to the resemblance between its symptoms and those observed after experimental cerebellar ablations. ONUF.

A Case of Gerlier's Vertigo.—Ackermann (*Centralblatt für innere Medicin*, March 2, 1895), describes a true case of this rare "neurosis." A laborer, 38 years old, was taken suddenly sick with severe pain in the neck, absolute ptosis of both eyelids, general weakness and loss of speech. After ten minutes the attack passed off. Similar spells were repeated at first monthly, but later more frequently. Between the attacks his health was good There were no evidences of alcoholism, arterial sclerosis or other disturbances of the nervous system or of the digestive organs. There existed, however, a marked left amplyopia, apparently congenital. Under treatment by rest and faradization there was no improvement, but the attacks disappeared during the employment of warm baths and two grammes of iodide of potassium a day. This the author considers an argument against the hysterical or neurasthenical nature of Gerlier's vertigo. FREEMAN.

Dr. W. H. Baker writes (*Boston Med. and Surg. Journal*, March 7, 1895) concerning the "Removal of the Uterine Appendages for Nervous Diseases." He outlines a somewhat hopeful spirit as to the effect of such removal, and gives two cases in which recovery followed, although a considerable time after the operation. He ends with the following summary:

"1. Diseases of the ovaries or fallopian tubes are sometimes an unrecognized cause of nervous disease.

"2. The adhesions resulting from attacks of localized pelvic peritonitis is a not infrequent source of nervous disease, either from the presence of pseudo-membranes in themselves, or from the interference which they offer to the functional activity of the organs involved.

"3. The extent or form of the pelvic disease is no indication of the character or degree of the resulting nervous manifestation.

"4. A most thorough pelvic examination should be made with the aid of an anæsthetic in every obscure case of nervous disease in a woman, occurring during the age of menstrual activity.

"5. Some forms of uterine disease may occasion an amount of nervous disturbance which may require the removal of healthy tubes and ovaries as the simplest and best mode of cure."

In the discussion Dr. Homans outlined his own cases, and expressed his belief in the curative efficacy of oöphorectomy as very slight. Dr. Edes and Dr. Davenport gave similar opinions.

Dr. Knapp said that he had never yet seen good results from it, and was "very doubtful about the cases of disease of the uterus, or ovaries, or any other organ of the body, giving rise to nervous disease, which does not at the same time give to certain symptoms, pointing to the organ itself." And again, "people are very glad to find some foreign cause rather than to admit the inherited or natural weakness of the brain." Dr. Prince expressed similar views, and particularly spoke against the too little lack of logical connection between remote slight causes and brain symptoms, He says farther concerning the symptoms themselves, "Certainly, the origin of many of these is not in the uterus, but in the mind itself" PHELPS.

Cerebral Anorexia.—O. Seltmann (*Centralblatt für innere Medicin*, March 2, 1895). In anorexia it is important to decide whether we have to deal with true impairment of the sense of hunger or with a want of appetite, whether or not there is abhorrence for food ordinarily, and accompanied or not by vomiting or nausea. The dyspeptic anorexia, which appears as a symptom and a consequence of original visceral disease, comes on between the second and seventh year in pampered and spoiled children, especially among the better classes. Seldom is the anorexia of nervous origin in these cases, but it appears as a true neurosis without assignable visceral disease in children encumbered by neuropathic heredity. In a twelve-year-old boy reported by S. this condition appeared, and led to almost complete food abstinence, with the highest grade of inanition. Hospital care and gavage were without avail, but faradization of the head led to a surprisingly quick cure. The current was passed through the post-auricular region and also obliquely through the head daily, each sitting occupying, at the most, two minutes. S. believes that by these means the cortical circulation was so influenced that an improvement in the nutrition of the cerebral cortex was brought about. FREEMAN.

Observations on Apoplexy.—C. L. Dana, M. D. (*Med. Record*, February 24, 1895). The term apoplexy as used in this article includes not only cerebral hæmorrhage, but also embolism and thrombosis. From a study of 182 cases observed, D. states that one-third of the patients were females, and that the special apopleptic age was between forty and fifty years. Three-fourths of all the adults were between thirty and sixty. After the age of seventy it was relatively rare. Syphilis was a factor in